West Virginia
Medicaid Member Agreement

Mountain Health Choice
Plan A - Adults

Medicaid Benefits at a Glance		
Benefit Description	**Basic (Adult)**	**Enhanced (Adult)**
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Not Covered	Not Covered
Inpatient Hospital Psychiatric Services	Not Covered	Prior Auth Required - maximum benefit of 30-days/year
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered
Physician Office Visits - specialty care*	Covered	Covered
Occupational/Speech/Physical Therapy	Covered - maximum benefit of 20/year Prior Auth Required *(Total allowed for all therapies combined)*	Covered Prior Auth Required
Weight Management	Not Covered	Covered NEW
Home Health Services	Covered - maximum benefit of 25/year (Prior Auth Required)	Covered (Prior Auth Required)
Durable Medical Equipment	Covered - limited to $1000 per year with Prior Auth required if limits exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Non-emergency Medical Transportation	Covered - maximum benefit of 10/year (5 round trips)	Covered
Ambulance Services	Emergent Only	Covered
Prescriptions	Limited - 4/month	Covered
Hospice	Covered	Covered
Emergency Dental Services	Covered	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Tobacco Cessation Programs	Not Covered	Covered
Family Planning	Covered	Covered
Cardiac Rehabilitation	Not Covered	Covered NEW (Prior Auth Required)
Pulmonary Rehabilitation	Not Covered	Covered NEW (Prior Auth Required)
Chiropractic Services	Not Covered	Covered (Prior Auth Required)
Podiatry Services	Not Covered	Covered
Chemical Dependency/Mental Health Services* (limited)	Not Covered	Covered - maximum benefit of 20 visits/year
Diabetes Education/Nutritional Counseling	Not Covered	Covered NEW
Nutritional Educational Services	Not Covered	Covered NEW
Nursing Home Services	Covered (Prior Auth Required)	Covered (Prior Auth Required)

*Psychiatrist/Psychologist Services covered under Specialty Care

Mountain Health Choices
Plan C - Children

Medicaid Benefits at a Glance		
Benefit Description	**Basic (Children)**	**Enhanced (Children)**
Well Child Visits (EPSDT Services)	Covered	Covered
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Prior Auth Required	Prior Auth Required
Inpatient Hospital Psychiatric Services	Prior Auth Required - maximum benefit of 30 days/year	Prior Auth Required
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered
Physician Office Visits - Specialty Care	Covered	Covered
Birth to Three Services	Covered	Covered
Occupational/Speech/Physical Therapy	Covered - maximum benefit of 20/year (total allowed for all therapies combined) (Prior Auth Required)	Covered (Prior Auth Required)
Weight Management	Not Covered	Covered New
Home Health Services	Covered - maximum benefit of 25/year	Covered
Durable Medical Equipment	Covered - limited to $1000 per year with Prior Auth required if limit exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Non-emergency Medical Transportation	Covered - 10/year (5 round trips)	Covered
Ambulance Services	Covered	Covered
Prescriptions	Limited - 4 per month	Covered
Hospice	Covered	Covered
Vision Services	Comprehensive eye exam, glasses - maximum benefit of $750/year	Comprehensive eye exam, glasses, contact lenses, vision training New
Emergency Dental Services	Covered	Covered
Dental Exams (dental check-ups)	Covered - 2/year	Covered
Hearing Services/Aids/Supplies	Annual exam and hearing aids when medically necessary	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Tobacco Cessation Programs	Covered	Covered
Family Planning	Covered	Covered
Cardiac Rehabilitation	Covered (Prior Auth Required)	Covered New (Prior Auth Required)
Pulmonary Rehabilitation	Covered (Prior Auth Required)	Covered New (Prior Auth Required)
Chiropractic Services	Not Covered	Not Covered
Podiatry Services	Not Covered	Covered
Chemical Dependency/Mental Health Services (limited)	Covered - maximum benefit of 26/year (Prior Auth Required)	Covered (Prior Auth Required)
Diabetes Education/Nutritional Counseling	Covered	Covered New
Nutritional Education Services	Not Covered	Covered New
Skilled Nursing Care (Private Duty Nursing)	Not Covered	Covered (Limited to 180 days/yr --Prior Auth Required)

Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)) and identified by an EPSDT (early and periodic screening, diagnostic and treatment services) screen will be provided either at the medical home or referred to an appropriate provider.

West Virginia Medicaid Member Agreement

This Agreement outlines your Rights and Responsibilities as a person in the West Virginia Medicaid Program. It also is about ways you can work with your doctor and other health care providers to become healthier.

MEMBER RESPONSIBILITES

1. I will follow the rules of the West Virginia Medicaid program.

2. I will do my best to stay healthy. I will go to special classes as ordered by my medical home.

3. I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.

4. I will pick a medical home within 30 days or one will be picked for me.

- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.

5. I will use the hospital emergency room only for emergencies.

MEMBER RIGHTS

1. I have the right to pick my medical home. This is where I go for check-ups or when I am sick and where my health care records will be.

2. I have a right to decide things about my health care and the health care of my children. I have a right to see my medical records. I have the right to ask questions about my health care and the health care of my children.

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3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the Medicaid Program.

4. I have a right to know about all laws and rules of the Medicaid Program.

5. I can contact Medicaid or my health plan with any questions about my health care.

6. I have a right to be sent a written notice when West Virginia Medicaid decides to deny or limit my Medicaid eligibility or services. I have a right to appeal a decision that says I have not kept my part of this agreement.

7. I have the right to appeal a decision that denies or limits my Medicaid eligibility or services. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

MEMBER ACKNOWLEDGEMENT

The information in this paper has been explained to me and I agree to follow this Medicaid Member Agreement.

_____ _____

West Virginia Medicaid Member Signature Date

_____

Witness: Title:

Location: _____

Date

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Patient/Clinician Health Improvement Plan for Enhanced Medicaid Benefits
Adult

Patient's Name_____ Medicaid ID Number_____

Date of Birth _____ Medical Home _____

1. Please indicate how often you and this patient have agreed that he/she will be seen at the health center (medical home) this year (**choose one**):

   O **One** visit to the primary care provider this year

   O **Two** visits to the primary care provider this year

   O **Three** visits to the primary care provider this year (approximately every 4 months)

   O **Quarterly** visits to the primary care provider this year (approximately every 3 months)

   O **Monthly** visits with the primary care provider this year

2. Please mark at least **two** of the following preventive and/or chronic illness care tests/procedures that you would recommend for this patient **in the next 12 months:**

   () Colonoscopy () Pneumococcal vaccination () Tetanus vaccination

   () Mammogram () Influenza vaccination () Lipid screening

   () Pap Test () Blood Pressure () Glucose level

   () Prostate Exam () Other_____

3. Health Education Classes. Please place a check mark in the appropriate box indicating if this patient needs education on any/all of the listed topics:

Nutritional Education ( )	Weight Management ( )	Diabetes Education ( )	Tobacco Cessation Education ( )

( ) I do not wish to sign the Member Agreement or to work with my medical home to develop a health improvement plan. By signing this, I am showing that I know that I will have the Mountain Health Choices Basic Benefit Plan.

Signature_____ Date _____

Witness _____

Patient/Clinician Health Improvement Plan for Enhanced Medicaid Benefits
Child/Adolescent

Patient's Name_____ Medicaid ID Number_____

Date of Birth _____ Medical Home_____

1. Please indicate how often you and this patient have agreed that he/she will be seen at health center (medical home) this year (**choose one**):

   O **One** visit to the primary care provider this year

   O **Three** visits to the primary care provider this year (approximately every 4 months)

   O **Quarterly** visits to the primary care provider this year (approximately every 3 months)

   O **Monthly** visits to the primary care provider this year

   O **Other** as per EPSDT periodicity schedule # _____visits

2. Please mark any of following preventive and/or chronic illness care tests/procedures you would recommend for this patient **in the next 12 months:**

   () Age appropriate immunizations () Lipid screening

   () Lead Screening () Glucose level

   () Other_____ () Dental Check-ups

3. Health Education Classes. Please place a check mark in the appropriate box indicating if this patient needs education on any/all of the listed topics:

Nutritional Education ( )	Weight Management ( )	Diabetes Education ( )	Tobacco Cessation Education ( )

( ) I do not wish to sign the Member Agreement or to work with my medical home to develop a health improvement plan. By signing this, I am showing that I know that I will have the Mountain Health Choices Basic Benefit Plan.

Signature_____ Date _____
(Parent or Guardian)

Witness _____